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ABSTRACT

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Power and Women's Psychological Disorders[1]

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Abstract

Power and women's mental health are considered from two perspectives. First, evidence that powerlessness is psychologically stressful is presented. It is argued that powerlessness associated with the female role may be responsible for women's elevated risk of psychological disorder. Second, the paper considers the extent to which psychotherapy is a vehicle for reducing women's powerlessness. It is noted that only a few therapies focus on increasing clients' power. A study of therapists suggested that male therapists with strong power orientations may seek out female clients. Furthermore, therapists with strong power orientations are more likely to endorse therapist-client sexual contact in the treatment situation. The need for more extensive study of power in psychotherapy is underscored by the seriousness of the issues.

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I'd like to begin with a story told to me by a clinical psychologist. She directs a well-regarded counseling service at a prestigious university. One of her colleagues is a male psychologist, ten years her senior. One day he addressed her as "Legs." She politely asked him to use her given name. He promptly accused her of being a "troublemaker." She explained her objections to the sexist connotations of "Legs." He shrugged this off and now calls her "Legs" frequently, even at staff conferences.

What has this story got to do with power? The context of the incident will shed some light on this. The woman holds a position senior to her colleague. Furthermore, it is quite apparent to the counseling staff that her clinical style is more congenial to counselees than is his. By using the anatomical nickname "Legs," this competence is denied. Her male colleague is able to create the illusion of superiority in their professional relationship.

There are many other stories of women professionals being put in a one-down position by their colleagues. However, it is more urgent to examine the situation of women clients in the mental health establishment. The remainder of this paper will be devoted to them. First, I will describe the evidence that loss of power or chronic powerlessness are antecedents of psychological disorder. The relationship between women's powerlessness and their psychological disorders will be discussed. Then I will consider power in psychotherapy relationships. Psychotherapy is a primary mode of treatment for psychological disorders and the majority of therapy clients are women. If psychological disorders originate in powerlessness, restoration of power should be a goal of treatment. It is doubtful that this is true in most therapy situations. Finally, the relationship between therapists' sex biases and power relations in therapy will be documented.

Powerlessness and psychological disorders

Actual or perceived powerlessness is accompanied by a heightened risk of psychological disorder. There is both correlational and experimental evidence to support this claim. Epidemiological statistics show that powerless individuals are at high risk for psychological disorders. The powerlessness engendered by poverty is associated with more psychogenic symptoms and more evidence of serious psychological disorder (Hollingshead & Redlich, 1958; Kleiner, Tuckman & Lavell, 1960; Srole, Langer & Michael, Opler & Rennie, 1962). Statistics collected by the National Institute of Mental Health (Cannon & Redick, 1973; Chesler, 1972) show that, over the past ten years, the number of women seeking treatment has risen more sharply than the number of men. Institutional sexism and traditional female socialization deny women power in both public affairs and private life.

Another source of evidence on the effects of powerlessness on the psyche derives from studies of life stress. Life stresses include events such as abrupt economic reversals, the death of a spouse or lover, or serious illness; these events temporarily lower one's sense of control over the environment and may reduce one's actual, as well as perceived, power. Studies of hospitalized individuals and door-to-door surveys have found that the occurrence of stressful life events precipitates an increase in psychological and psychosomatic symptoms. The end result may be full-blown psychological disorders (Frank, 1972; Dohrenwend, 1973; Myers, Lindenthal & Pepper, 1974).

Laboratory experiments provide a third source of evidence. These experiments create situations of "powerlessness" by placing subjects under conditions in which their responses have no effect on environmental contingencies. In other words, the subject connot establish any control over environmental

events such as electric shock. Results of experiments done on species ranging from goldfish to humans show that this condition of "powerlessness" (i.e., the noncontingency of responses and reinforcements) has severe consequences for mood and behavior (Seligman, 1975). Listlessness and passivity result and attempts to cope with the environment may cease.

I have now described research on three types of powerlessness: chronic powerlessness produced by social inequities; temporary powerlessness resulting from personal catastrophes; and the powerlessness induced in the behaviorist's laboratory. All three research paradigms reach similar conclusions: powerlessness and lack of control have negative psychological and behavioral consequences and may be linked to psychological disorder.

Powerlessness and women

Power and powerlessness were not conscious concerns of many women prior to the current Women's Liberation Movement. From a feminist vantage point, however, it became apparent that our sexual status defined the limits of our power. Women have less power than men; this is true in their personal, economic, social and political lives. Traditional feminine role requirements demand that women give in to others' wishes, subordinate their needs to others, and relinquish decision-making power. Studies of traditional marriages (Barry, 1970; Bernard, 1971) suggest that wives in these relationships are expected to give up personal autonomy and power to their husbands. Nonemployed wives with young children may experience the most severe sense of powerlessness. They are expected to respond to their offsprings' needs on demand and put aside their own needs as long as necessary. They may not have any funds over which

they exercise control. They are often isolated from other adults and, if the isolation is prolonged and intense enough, it may cause a sense of alienation from the "real world" and self-doubts about social abilities necessary to cope in it.

Personal relationships are not the only area of reduced power for women. Occupational discrimination in hiring, promotions and salaries reduce women's control over their work life. There are few government officials who respond to the political interests of women. Discriminatory credit practices, though diminishing, continue to give women less control over their personal finances than men have. Thus, there are many areas of life experience in which women have less power and fewer resources than men. If the theory that powerlessness has negative psycholgical consequences is correct, female sexual status should raise the risk of psychological disorder.

Does the evidence justify our concern about women's risk of psychological disorder? The answer is clearly affirmative. Statistics show that women are at higher risk for psychological disorder than men. The social institution of marriage raises women's risk of disorder but lowers men's (Bernard, 1971; Cannon & Redick, 1973). Married women who are not employed outside the home are at the highest risk for psychological disorder. There are many indicators of risk. First, housewives have the highest rates of entry into psychiatric treatment of any occupational group. They request and receive from their physicians the greatest quantity of prescribed mood-modifying drugs (New York Narcotic Addiction Control Commission, 1971). They report the highest incidence of psychogenic symptoms such as nervousness, nightmares, dizziness, headaches and so on (Lief, 1975). Female roles carry an

elevated risk of psychological disorder; more traditional roles appear to be correspondingly more hazardous.

Sex differences in psychological disorders

The discussion thus far has been grossly oversimplified in one important respect. I have spoken about psychological disorder as if it was a unitary phenomenon. By doing so, the sticky problems of diagnostic classification have been avoided. However, we have overlooked some pertinent information concerning sex differences in specific psychological disorders. While there are few psychological disorders that are exclusively male or female, risk for specific disorders differs markedly for men and women. What is of interest is that men and women are at high risk for types of psychological disorders that dovetail with masculine and feminine stereotypes, respectively.

Women are at heightened risk for disorders marked by symptoms of low self-esteem, self-punitiveness, passivity, guilt, depression, and social withdrawal. These symptoms easily lead to helplessness, apathy, and an inhibition of assertiveness. Thus, the psychological disorders which women are most likely to experience exacerbate powerlessness.

Men are at heightened risk for psychological disorders involving antisocial behavior, aggression and violence, criminal acts, impulsiveness and psychopathy. These "masculine" symptoms differ from those characteristic of women's disorders in two ways. First, they involve behavior directed against others rather than against the self. Second, they involve an active orientation, rather than a passive one. As reactions to psychological stress, "masculine" behaviors seem to be active attempts to gain or reestablish a sense of control over the environment.

We can fit another piece into the puzzle by considering these sex-typed

symptoms of psychological disorders in light of evidence on sex-role norms guiding the expression of power. Johnson's work (1974) has shown that men characteristically use direct expressions of power while women use indirect ones. Experimental evidence (Costrich, Feinstein, Kidder, Marecek and Pascale, 1975) suggests that social penalties are heaped upon women who assert themselves in a direct fashion and men who fail to do so. Our everyday language usage also shows this. We have deprecating terms for women who assert themselves--castrating, bossy, domineering, bitchy--and for men who do not--Casper Milquetoast, pansy, impotent. Thus, it is normative for women to be less assertive than men; this sex difference in expressions of power seems to apply both to persons suffering psychological disorder and to persons regarded as psychologically healthy.

Power and psychotherapy

If powerlessness has bad psychological consequences, we might expect clinical theory and treatment to be concerned with the restoration of power to clients. Contrary to this expectation, there is relatively little attention devoted to this issue in the classical literature on psychotherapy. In fact, only two therapy techniques-both recent innovations-focus specifically on increasing clients' power. The first of these, assertive training, teaches clients to exercise social power in an assertive, nonaggressive manner without experiencing guilt. The therapeutic process consists of assertive exercises in fantasy, role play, or real situations, designed to produce confidence and skill in taking assertive stances. Assertive training has been used extensively for female clients (Bower & Bower, 1976; Fodor, 1974). The other therapy dealing directly with building clients' power is also a behavior therapy. It is derived

from Seligman's 1975 theory of depression as learned helplessness. The theory regards clients' feelings of lack of control over the environment as the root of clinical depression. Depressed individuals in treatment engage in experiences designed to re-establish their sense of control over the environment.

Formal theories do not tell us the whole story about psychotherapy. To understand how power operates in psychotherapy, process is a more important focus than theory. Personal characteristics of the therapist and the relationship between therapist and client are important ingredients--perhaps the most important--in therapy outcome. In theory, the patterns of interaction established between the therapist and client serve as a model for the client's behavior outside therapy. What if the therapist encourages the client to use ineffective or demeaning ways of getting her needs met, such as acting helpless or flattery? What if the therapist takes complete charge of all decisions regarding the client's treatment? It is unlikely that the therapy experience will increase the client's social power in everyday life, regardless of the therapist's intentions.

Another reason for studying power in the therapy process is our concern with female clients. We have already seen that our cultural conceptions of the female sex-role do not allow women much power. Furthermore, the sex-role-appropriate ways for women to express power are relatively indirect and demeaning and they erode self-esteem. There is every reason to expect that cultural biases regarding women and power will invade psychotherapy relationships. Therapists have been shown to share cultural stereotypes of male and female personality traits (Broverman, Broverman, Clarkson, Rosenkrantz & Vogel, 1970) and to base treatment recommendations on these stereotypes (Thomas and Stewart, 1971; Masling and Harris, 1969; Harris and Masling, 1970; Taube, 1973).

There are several other sources of evidence that various phases of treatment are influenced by sex biases which pervade the mental health establishment. It is virtually certain that, when the formidable study of sex bias in therapy processes is undertaken, sex bias will be found in alarming abundance. And, those sex biases which invade our power transactions in everyday life are likely to be found in psychotherapy as well.

My own research suggests that our concern with power and sex bias is not a needless one. Susan Packer and I studies therapist's power orientations and their attitudes about various treatment practices and ethical issues. Power orientation was measured in two ways. First, a scale measuring Machiavellian personality orientation (Mach IV) was administered. Machiavellianism is a personality orientation involving willingness to manipulate others, lack of concern for conventional morality, willingness to exploit others in pursuit of personal goals, and emotional detachment in interpersonal situations (Christie and Geis, 1973). Second, a list of four key factors operative in psychotherapy was compiled.[2] Three dovetailed with psychoanalytic, Rogerian and behavioral theories of therapeutic change. The fourth factor involved therapists' power. Following the theories of Haley (1963) and Erickson, the key elements of therapy were described as "direct personal influence, persuasion, advice-giving and charismatic inspiration." The therapists were asked to indicate the importance of each factor for doing therapy successfully.

We sampled therapists at random from the membership of the Division of Psychotherapy of the American Psychological Association and contacted them mail. Our return rate of 55% was rather low, but comparable to that achieved by other studies using similar methods and subject populations. Unfortunately, the distribution of therapists by sex was very uneven: forty-three men and twelve

women participated.

Therapists' scores on the Machiavellian scale are shown in Table 1. Mean scores of male therapists were comparable to the population norm. HOwever, our sample of female therapists had scores considerably higher than the norm. Whether this reflects statistical error due to the small sample size is a question best answered by further research. Nonetheless, other studies have found professional women to have more Machiavellian orientations than their nonprofessional counterparts.

Our main focus was not on Machiavellianism *per se* but, rather, on the relationship of Machiavellianism to therapy practices. We found that Machiavellian therapists were likely to favor the use of placebo drugs in treatment (r (53) = .34, $p < .03$) and to favor coercing individuals into treatment (r (53) = .31, $p < .05$). Among male therapists, Machiavellianism was strongly linked to a preference for treating female clients (r (41) = .40, $p = .008$). Among female therapists, a zero order correlation obtained. Why does male therapists' predilection for interpersonal manipulation coincide with a preference for treating women? This is not a pleasant question to contemplate.

A more direct index of power orientation in therapy was provided by the ratings of the key elements of therapy. Nineteen percent of the therapists rated the Control factor as very important to therapeutic success. As shown in Table 2, women regarded this "Control" factor as more important than men did, thus giving us more confidence that the sex difference in Machiavellianism was not an artefact.

Our data suggest that the Control factor in therapy is relevant to a prominent concern of feminists (Chesler, 1972; Asher, 1975). This concern is the sexual exploitation of women in therapy. We asked our respondents if sexual relations in therapy were permissible and, if so, under what circumstances.

Male therapists who endorsed the importance of control also felt that sexual relations in therapy were permissible (χ^2 (1) =4.42, $p < .05$). Furthermore, the more important control was to a therapist, the more circumstances were given in which therapist-client sexual contact was permissible (r (53) = .25, $p < .06$). Thus, the issue of power in therapy has important consequences for the way women are treated. The findings presented here are hardly the complete story, but they serve to illustrate the importance of the question of power in psychotherapy and its relevance to women clients.

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Footnotes

1. Presented at meetings of the American Psychological Association, Chicago, September, 1975.
2. This list was generated from a previous research project (Packer, 1973) which asked therapists to identify the elements of psychotherapy which they regarded as crucial to success.

Table 1

Mach IV scores of therapists and college students[a]

	Therapists			College Students[b]		
	M	S.D.	N	M	S.D.	N
Males	93.78	10.25	43	93.69	14.37	764
Females	97.48	12.04	12	87.66	13.45	832

[a] The Mach IV scale contains 20 items, answered on a 7-point scale, ranging from strong disagreement (1) to strong agreement (7). A constant of 20 is added to the scores. Thus, 100 is the theoretical neutral point.

[b] Christie and Geis, 1970, p. 32.

Table 2

Importance of control in therapy: Therapists' ratings[c]

	M	S.D.	N
Males	1.86	0.68	43
Females	2.04	.66	12

[c] Rated on a 3-point scale, ranging from Not important (1) very important (3).